



**Office of
Mental Health**

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Executive Deputy Commissioner

February 22, 2019

Denise M. Miranda, Esq.
Executive Director
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054

Dear Ms. Miranda:

We received your letter dated January 25, 2019 in response to the Justice Center's review of the mental health services provided to Joseph King (DIN #13A3662), an inmate/patient who died on November 16, 2018 at the Midstate Correctional Facility (CF).

OMH would like to note that the "Background" section of the Justice Center's report states Mr. King was made a Mental Health Service Level (MHSL) 2 in February 2016; however, he was made a MHSL 2 on January 8, 2015 – this is accurately reflected on the Chronological Record and on the Treatment Needs/Service Level Designation Form in the clinical record.

Below are the Justice Center's findings and recommendations, from the above-referenced review, and OMH's response to each. The CBO Risk Management Special Investigation Report has not yet been finalized via the Incident Review Committee (IRC); therefore, the report is not enclosed with this response. The CBO Risk Management Special Investigation report will be sent to the Justice Center once it has been finalized.

Recommendation #1:

"The OMH Clinical Director or Regional Psychiatrist should complete a comprehensive review of the mental health treatment afforded to Mr. King in the six months leading up to his death and provide the Justice Center with any documentation demonstrating his course of care was reviewed and evaluated to ensure the appropriateness of:

- a. the psychiatric medication administration practices and;
- b. the clinical care provided to an individual with a history of suicide attempts, substance use and chronic/acute suicide risk factor and warning signs."

OMH Response:

Both the CBO Clinical Director and regional consulting psychiatrist reviewed Mr. King's case. OMH does not agree with the Justice Center's claims regarding Mr. King's medication regimen or that "OMH failed to recognize the suicide risk factors and warning signs displayed by Mr. King prior to his suicide...there was minimal documentary evidence that additional support, programming or crisis intervention was offered."

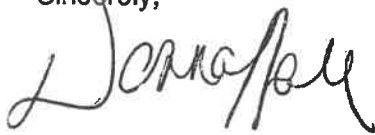
Clinical documentation demonstrates Mr. King's medication was discussed and addressed at every psychiatric callout. Most medication changes were implemented in response to his feedback about efficacy or lack of efficacy of the medication, or about the experience of negative

side effects. Another area of consideration was his ongoing use of Suboxone. Suboxone can have synergistic toxicity with trazodone, thereby raising patient safety concerns. Despite the medication changes made in response to his concerns and education provided to him regarding the risk of using Suboxone, Mr. King continued to use Suboxone and refuse his prescribed medication, which ultimately led to discontinuation. Additionally, as an indication of staff's efforts to be responsive to Mr. King, the psychiatrist met with Mr. King more frequently than required; he was assessed by psychiatric staff monthly in the six months preceding his death.

As noted by the Justice Center, OMH staff clearly documented knowledge of Mr. King's suicide attempt history, and his reports of feeling "depressed, anxious, worried, not sleeping, had decreased motivation and was concerned about his upcoming parole board." Ongoing and thorough clinical assessment determined that Mr. King did not meet criteria for acute crisis intervention services, as he neither threatened to harm himself or others, nor did he display self-harming behaviors indicating imminent risk. Psychotropic medication and psychotherapy were reviewed with him and offered. The treatment team continued to work with him, per policy and as needed, to address his treatment needs while continuing to assess his risk for suicide.

We thank you for bringing your concerns to our attention.

Sincerely,

A handwritten signature in dark ink, appearing to read "Donna Hall", written in a cursive style.

Donna Hall, Ph.D.
Associate Commissioner
Division of Forensic Services

Enclosed

cc: Deborah J. McCulloch, Executive Director, CNYPC
Lori Schatzel, Director, Corrections Based Operations, CNYPC
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